

FILED NOV 24 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 38561  
9619

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>				c. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>5567 Pershing</b>				d. STREET ADDRESS (If rural, give location) <b>5567 Pershing</b>			
3. NAME OF DECEASED (Type or Print)		a. (First) <b>JENNIE</b>		b. (Middle) _____		c. (Last) <b>GROSBERG</b>	
4. DATE OF DEATH <b>Nov. 13, 1950</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED <b>Widow</b>	
8. DATE OF BIRTH <b>Unknown</b>		9. AGE (In years last birthday) <b>Abt. 85</b>		10. UNDER 1 YEAR Months _____ Days _____		11. UNDER 25 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>				10b. KIND OF BUSINESS OR INDUSTRY _____			
11. BIRTHPLACE (State or foreign country) <b>Russia</b>				12. CITIZEN OF WHAT COUNTRY? <b>6</b>			
13a. FATHER'S NAME <b>Fulius Yondel</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Morris J. Grosberg</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Barney Grosberg-6361 Washington</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Acute Coronary Occlusion</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Coronary Sclerosis</b> DUE TO (c) <b>Arterio Sclerosis</b> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Chronic Myocarditis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>15 YRS</b> <b>20 YRS</b> <b>20 YRS</b>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____		21f. HOW DID INJURY OCCUR? <b>H201</b>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22. I hereby certify that I attended the deceased from <b>Feb 1940</b> , to <b>Nov 13, 1950</b> , that I last saw the deceased alive on <b>Nov 13, 1950</b> , and that death occurred at <b>5 P.M.</b> , from the causes and on the date stated above.			
23a. SIGNATURE <b>Earl O. Lieberman, M.D.</b>		(Deputy or title) _____		23b. ADDRESS <b>508 N. Grand</b>		23c. DATE SIGNED <b>11-13-50</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>11/14/50</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Beth Hamedrosh Hagodol</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>	
DATE REC'D BY LOCAL REG. <b>NOV 13 1950</b>		REGISTRAR'S SIGNATURE <b>J. B. Linder</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Wm. A. Rindke, Inc. 5216 Delmar</b>			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_

*John Ketter*  
Licensed Embalmer No. *3880*

Signed \_\_\_\_\_  
Student Embalmer

P. O. Address \_\_\_\_\_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.